TRICARE MANAGEMENT ACTIVITY

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Table of Contents

Section 1 - Program Integrity

The TRICARE Program Integrity (PI) Office is responsible for all anti-fraud activities worldwide for the purchased care sector in the Military Health System. PI is responsible for developing policies and procedures regarding prevention, detection, investigation and control of TRICARE fraud, waste and program abuse, monitoring contractor program integrity activities, coordinating with DoD and external investigative agencies and initiating administrative remedies as required. During the time period covered by this Operational Report, the TRICARE Management Activity (TMA) PI Office reported to the Director, Acquisition Management and Support. In January of 2003, the Office was reassigned to the Resource Management Directorate reporting to the Director of the Defense Health Program Management Control & Financial Studies Office.

TMA PI provides technical assistance, program expertise and support to the DoD Office of the Inspector General (IG) for Investigations and to U.S. Attorneys in developing cases for prosecution, to include expert witness testimony. Through a Memorandum of Understanding, PI refers its provider fraud cases to the Defense Criminal Investigative Service. PI coordinates investigations with offices and agencies of the Department of Justice, DoD IG, various Military Departments and federal, state and local agencies. PI administers the administrative procedures related to provider exclusions, suspensions, terminations and reinstatements. In April of 2002, TMA's Office of Administration became the central point of coordination for all DoD Hotline complaints previously handled by TMA PI.

As a member of the National Health Care Anti-Fraud Association (NHCAA), TMA PI shares fraudulent billing schemes with other private and public health care plans. In December 2001, for the first time in its 17-year history, the NHCAA selected TMA PI as the public sector representative to its Executive Committee. TMA PI is also the TRICARE Liaison Member of the Department of Justice Health Care Fraud Working Group. TMA PI works with the FBI, state investigative agencies, and the numerous health care fraud task forces established throughout the United States. These health care fraud task forces have representatives from the entire spectrum of Government and private health care plans.

TRICARE's Operation Fraud Watch

In September 1999, TMA PI launched TRICARE's Operation Fraud Watch with the support of TMA's then Executive Director, Dr. James T. Sears, at a fraud training conference held in Myrtle Beach, South Carolina. The Myrtle Beach site was chosen to promote attendance at the conference by TRICARE's largest claims processing subcontractor, Palmetto Government Benefits Administrators (PGBA), located in Florence and Surfside Beach, South Carolina. Representatives attended from most of TRICARE's prime contractors including Anthem Alliance Health Insurance Company; Foundation Health Federal Services, Inc.; Humana Military Healthcare Services; Sierra Military Health Services;

and United Concordia Company, Inc.; as well as the other claims processing subcontractor, Wisconsin Physicians Service.

The initial conference was a tremendous success and attended by various Government agencies that work together to combat fraud. As a result of this conference, an agreement was made between TMA and the Defense Criminal Investigative Service (DCIS) to alternate sponsoring the conference.

Dr. James T. Sears was invited to attend the press conference announcing the Columbia Hospital settlement in December 2000. Attorney General Janet Reno publicly recognized and praised TMA's contribution to the investigation and settlement which resulted in a return to TRICARE of $7.4 million.

Training and Educational Efforts

Between March 27, 2001 and December 31, 2002, there have been over 11,800 visits to the TRICARE Fraud and Abuse Web Page, which now features a direct link to the Managed Care Support and the National Dental Contractors' web pages. This feature allows beneficiaries and providers to report fraud and abuse online, directly to a contractor's Program Integrity Unit, when available. The Fraud and Abuse Web Page is accessed through the Reporting Fraud link which brings up a map of the TRICARE Regions. The user clicks on the appropriate region and the contractor's name, address, and hotline telephone number appear. Clicking on the contractor's name connects the user to the contractor's web page where there are instructions on how to report fraud to the contractor's Program Integrity Unit. Based on the number of visitors to the fraud and abuse web page received so far, we believe this new function enhances the effectiveness of the office, maximizes utilization of the contractor's program integrity staff, and provides another way for beneficiaries to report suspected fraud against the TRICARE program.

On June 25, 2003, TMA PI will host the fourth TRICARE National Health Care Fraud Conference. The two and one-half day conference will be held at the Nikko Hotel in San Francisco, California. This year's theme is "Maintaining Quality & Excellence in Health Care Fraud Detection." Presenters from the Department of Justice, the Federal Bureau of Investigation, DCIS, TMA's Program Integrity Office, and others will provide comprehensive training courses full of health care fraud information. The audience will consist of investigators, attorneys, health care contractors and industry experts.

In April 2002, the recipient of the Contractor Performance of the Year 2001 Award for its work in detecting fraud and abuse, Humana Military Health Services, hosted the first Contractor Information Sharing Roundtable Session. The second Roundtable session was hosted by the Director, Pharmacy Data Transaction Service in San Antonio, Texas. The participants included TMA's Program Integrity Office, DCIS, Managed Care Support Contractors (MCSCs), the national dental contractor, the mail order pharmacy contractor, and Pharmacy Data Transaction Service personnel. The contractors, normally in competition with each other, removed barriers to communications, shared information and conducted brainstorming sessions designed to increase the effectiveness of their anti-fraud units. The initial purpose for these sessions was centered on making each program integrity unit stronger. This was accomplished and much more. The Roundtables energized all attendees to keep abreast of new and innovative methods of investigating health care fraud cases. These sessions generated enormous amounts of interest to both the Government and contractor attendees and provided prime opportunities for everyone to participate, teach, train and educate. Most importantly, it raised the level of awareness and impact of everyone's anti-fraud efforts during 2002.

The first Army-sponsored Beneficiary Counseling and Assistance Coordinator Video-Tele Training, was held in November 2002. TMA PI was one of nine TMA presenters providing information to 17 training sites.

TMA PI takes an active role in training and educational efforts related to fraud and abuse. In 2002, the Office was directly responsible for providing fraud and abuse training and computer and technical program support to more than 1,550 people. Organizations that attended the varied training programs include the Department of Army, Department of Air Force, Department of Navy, DCIS, United States Coast Guard, Department of Justice, Federal Bureau of Investigation, Department of Health and Human Services, and organizations outside of the federal Government. Speakers from the Program Integrity Office provided training at the following courses: the TRICARE Basic and Advanced Student Course; the Federal Health Care Acquisition Conference, multiple Lead Agent conferences; the orientation for the Lead Agent Medical Directors; the Department of Health and Human Services, training for Defense Criminal Investigative Service; and the TRICARE National Conference.

Section 2 - TRICARE Clinical Quality Forum

Because of the recognized relationship between quality of care and health care fraud, TMA PI is a member of the TRICARE Clinical Quality Forum, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA))/TMA Committee with oversight responsibility for clinical quality assessment programs. The Forum's primary responsibility is to monitor and assess the quality of health care provided to Department of Defense beneficiaries and to report findings in an annual report to the ASD(HA). The Forum is an important vehicle for providing recommendations to senior leadership pertaining to the future clinical quality initiatives and oversight programs. The Forum contributes to ensuring quality and cost effective care for military families whether the care is received in the military direct care system or through the purchased care side of TRICARE.

Impact of Fraud on the Quality of Care

The ability to provide affordable, quality health care to military families and other citizens of the United States in a cost effective manner continues to be a goal of the TRICARE program. Fraud can adversely impact quality of care and result in patient harm when profit is more important than what is in the patient's best interest.

Identification of potential patient harm cases (regardless of the dollar amount) and determining and notifying TRICARE beneficiaries as quickly as possible that they may be affected continues to be a TMA PI priority. Toward this end, TMA PI staff members met with the Deputy Director for Network Performance Assessment & Improvement, Clinical Quality Division (CQD), TMA and OASD(HA). Attendees discussed ways to better integrate Managed Care Support Contractors (MCSCs) and CSC quality oversight with the work in TMA PI and CQD. A shared concern is those providers who may have misrepresented their credentials in order to become authorized. This may impact the quality of care received by TRICARE beneficiaries. Both TMA PI and CQD recognize the need for establishing mechanisms to link our program efforts. Such a cooperative effort would be beneficial in identifying and notifying patients exposed to aberrant practices. This was demonstrated in a recent case involving patients of a particular provider seen at a Nebraska clinic who may have been exposed to Hepatitis C through the use of dirty needles. CQD assisted TMA PI in ensuring that all TRICARE patients were notified of the potential risk of infection and what medical attention they should seek.

Case Study: James F. Graves, Jr., M.D.- Quality of Care Issue

In February 2002, James F. Graves, Jr., M.D., was convicted of four counts of manslaughter, five counts of drug trafficking and one count of racketeering, in connection with the deaths of five patients who had overdosed on drugs such that he prescribed. Graves, who advertised himself as a pain management specialist prescribed a potentially lethal mix of medicines pharmacists dubbed a "Graves Cocktail." The mix included OxyContin, Lortab, Soma and Xanax. Evidence presented at trial was provided by TRICARE, Medicaid and private insurance representatives concerning claims for services provided by Graves in comparison to the claims for prescriptions he issued. Among the first physicians in the country to be tried and convicted on charges that his OxyContin prescriptions resulted in death, Graves was sentenced to 755 months (62.9 years) incarceration on March 22, 2002. This case generated a great deal of national media attention, to include a post-conviction jailhouse interview of Graves by Charles Gibson on "Good Morning America."

Case Study: Herbert A. Daniels, M.D. - Quality of Care Issue

On May 30, 2002, Herbert Arnold Daniels, M.D., was sentenced in U.S. District Court, Kansas City, KS, to 72 months incarceration and 36 months of supervised probation upon release. As part of the sentence, Daniels agreed to a 15-year exclusion from Medicare, TRICARE, Medicaid and all Federal Health Benefit Programs. The exclusion period begins after his release from prison. The scheme to defraud included subjecting TRICARE patients, and others, to unnecessary surgery; billing for multiple complex surgical procedures he could not have performed; and falsifying tests to justify unnecessary surgeries. Daniels was indicted for (1) billing for services not rendered; (2) upcoding, that is charging for a service reimbursable at a higher rate than appropriate for the service actually provided, which would increase his revenue and (3) luring patients to surgery, which could cause and did cause serious bodily injury to patients, one of whom lost her hearing, underwent substantial pain and suffering and had to undergo two remedial surgeries and (4) covering up the fraud by creating false documents. It was alleged that both children and the elderly were exposed to the risks of general anesthesia as they were told that surgery at a hospital was required when the patient could have been treated medically without surgery or in the office under local anesthesia. The jury returned guilty verdicts on 43 of the 47 counts, acquitting Daniels on the remaining 4 counts. Daniels was convicted on 33 counts of health care fraud, 7 counts of mail fraud, and 3 counts of perjury.

Section 3 - TMA Program Integrity Activity Report, 1999-2002

During 2002, TMA PI opened 239 new cases, responded to 562 requests for assistance, evaluated 201 new *qui tam* cases and closed 247 cases. A *qui tam* is a provision of the Federal Civil False Claims Act that allows private citizens to file lawsuits in the name of the U.S. Government charging fraud by Government contractors and others (e.g., health care providers) who receive or use Government funds and share in any money received. This unique law facilitates the effective identification and prosecution of Government procurement and program fraud and the recovery of revenue lost as a result of the fraud.

The chart below shows the results of TMA PI's activities over the last four years. Launched in late 1999, OPERATION TRICARE Fraud Watch, with its increased emphasis on anti-fraud programs, had an impact on the early identification of fraud, thus minimizing dollar losses within the program. The National Health Insurance Association of America has estimated that for every $1 spent on anti-fraud activities, $11 is saved.

DESCRIPTION	1999	2000	2001	2002
Qui-Tams	256	181	141	201
Civil Cases Settled	92	138	61	67
DoD Hotlines	32	11	31	12*
Written requests for consultation, case support, or assistance from DCIS, DOJ, and other law enforcement entities	584	600	532	562
Cases referred to DCIS	202	128	122	206
Cases referred to Military Criminal Investigative Offices	8	5	5	0
Balance Billing and Violations of Participation Agreement	57	29	42	56
Providers Sanctioned	2,976	2,709	3,756	3,582
TRICARE dollars identified for recovery (Fiscal year)	$2.9 million	$1.12 million	$11.2 million	$2.3 million

*April 2002 TMA's Office of Administration took over the responsibility of coordinating all DoD hotline complaints.

Fraud Judgments

Thus far, TRICARE has received judgments for $2.3 million dollars for fiscal year 2002. The dollars returned are shared with the managed care support contractors at the rate of approximately 20% of the dollars recovered, depending on the dates of care involved in the judgment and the terms of the contract. Another $1.8 million resulted from administrative recoupments. The remaining dollars are disbursed among the various branches of the Uniformed Services as TRICARE benefit dollars. It should be noted that the sharp decline in fraud judgment dollars between fiscal years 2001 and 2002 is directly attributable to the shift in law enforcement priorities as a result of the 9/11 attack on the Pentagon and the destruction of the World Trade Center twin towers in New York. Their investigative efforts focused on anti-terrorist activities and homeland security during this time frame.

TRICARE's National Database

TMA's National Database continues to be the cornerstone of TMA PI's investigative efforts. To respond to those who investigate or prosecute fraudulent practices, TMA PI uses the TRICARE Care Detail Information System or CDIS. This database captures all care rendered and paid for by TRICARE in a Health Care Service Record (HCSR) format. The HCSR maintains information on covered beneficiaries and the care each receives. The HCSR facilitates the investigation of allegations of fraud and abuse through analysis of a suspected provider's billing patterns and an assessment of the cost impact for use by the Department of Justice in its settlement negotiations.

The HCSR is derived from data forwarded by TRICARE MCSCs in a specific format that is run against a specific set of quality control edits. Although the data requirement contributes to data integrity and the fiscal soundness of a single audit trail, the extensive information required places an administrative burden on the MCSCs. Therefore, with the implementation of the next generation of contracts, the TRICARE Encounter Data System (TED) will replace the HCSR. TED will be the new, streamlined, collection of purchased care data from the contractors that will be used to meet Government requirements for health care information. Implementation of TED will comply with the requirements cited in the National Defense Authorization Act for Fiscal Year 2001 and will promote efficiencies and cost savings for the contractors and the Government. TED will also improve TMA's ability to implement the Health Insurance Portability and Accountability Act of 1996 requirements, which provide for more timely access to purchased care data, and capture critical fields such as the National Drug Code, Referring Physician, and National Provider ID (when implemented).

TMA PI continues to be an active member of the Integrated Process Team involved in the development of TEDs and the new Patient Encounter Processing Reporting System (PEPR) which will capture, edit and store the TEDs. TMA PI's input into the development of these systems is important if the Office is to continue to provide the level of information required to fight health care fraud and abuse against the TRICARE program.

Section 4 - Affiliations

Relationship with the Defense Criminal Investigative Service (DCIS)

In Fiscal Year 2002, TRICARE provided services for over 8 million eligible beneficiaries worldwide. The health care budget for the Department of Defense is $17.6 billion. This includes the Military Treatment Facilities and the non-defense facilities. Federal health care programs working collaboratively were able to identify $19,334,603 in criminal cases and $76,919,888 in civil cases for a grand total of $96,254,491 federal dollars in judgment. The federal programs include TRICARE, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). The following vignettes illustrate successful recovery efforts.

Case Study: Ralph J. Sharow, D.M.D.- Billing for Services Not Rendered

On January 16, 2002, Ralph J. Sharow, a Freehold, NJ, dentist, pled guilty to a 2-count Criminal Information charging one count of health care fraud and one count of income tax evasion. The investigation revealed that Sharow routinely billed TRICARE and private dental insurance programs for dental procedures called three surface amalgam restorations and dental sealants that were never performed. He falsified patients' dental records and falsely reported patients' addresses to the insurance companies. The false addresses insured that the dentist would receive the explanations of benefits instead of the patients since that would have alerted them to the fraudulent billings. The investigation also revealed that Sharow kept two sets of records on his dental practice--one accurate set, the other grossly under reported. The latter was used to file false tax returns. On July 17, 2002, Sharow was sentenced to 27 months incarceration for each of the two counts, with the terms to run concurrently; two concurrent terms of three years probation; a $200 special assessment; and the payment of restitution in the amount of $264,363.90. The amount owed to TRICARE was $20,106.46.

Case Study: Eckerd Corporation - Charging for Services Not Provided

An investigation was initiated based on allegations that the Eckerd Corporation (one of the largest pharmacy chains in the United States) defrauded TRICARE, Medicaid, and Federal Employees Health Benefits Program (FEHBP) by filing false claims for prescription payments. Identified were numerous instances where Eckerd was unable to completely fill some prescriptions and although instructed to do so, patients failed to return at a later date to pick up the rest of the prescriptions. The investigation revealed that when a patient did not return for the balance of the prescription, the drugs were returned to stock or resold to other customers. Eckerd did not credit the Government program accounts with the costs of the portion not provided to the patient. On June 4, 2002, Eckerd agreed to a civil settlement with the Government totaling $9 million to resolve allegations of making false claims, receiving unjust enrichment, and breach of contract with respect to payment of prescription medication claims to the TRICARE, Medicaid and FEHBP. Of the $9 million agreed upon, TRICARE received $173,410.34.

Case Study: Hospital Corporation of America, Inc. - Falsified Records

On December 18, 2002, the Hospital Corporation of America, Inc. (HCA), formerly known as Columbia HCA, announced that a $631 million settlement agreement had been tentatively reached. If approved by the Justice Department, the agreement would resolve Medicare/TRICARE inflated cost report issues as well as other civil health care fraud allegations that have been under investigation for five years as a result of a qui tam suit filed against HCA. To date, negotiations between the Department of Justice and HCA continue. The amount TRICARE will receive once the settlement agreement is final is unknown at this time.

Relationship with the Defense Contract Audit Agency (DCAA)

TMA PI formed an alliance with DCAA, which began in April 2002 when the first Financial Advisor (FA) was assigned to work with and provide support to TMA PI in a number of varying capacities. The first project involved the review of data obtained from the Arizona Board of Medical Examiners website. The FA automated the Arizona providers credential data to determine if TRICARE physicians listed in Arizona held a valid license to practice. In this project, the FA was able to validate the licensure for all but 58 of the 11,000 TMA physicians in Arizona. The Managed Care Support Contractor will revalidate the remaining 58 to ensure they meet the licensing requirements.

Data mining for all care rendered in the state of North Carolina is another significant project the FA is actively involved in. The data has been transferred to DCAA where they will be creating a database on their mainframe in Tennessee. Various fraud scenario queries will be executed against the data utilizing Statistical Applications Software (SAS) applications and DCAA's experience in data patterning. All findings will be discussed and turned over to TMA PI for further development.

The FA has also assisted the TMA PI staff in a number of other ways to include assisting with statistically valid audit plans, provider peer comparisons, and various data reviews focusing on diagnostic testing, ambulance, and duplicate billing scenarios. In the coming year, the FA will be involved in additional projects and audits. TMA PI values the contributions that have and will

continue to be made through this important alliance, ultimately benefiting both taxpayers and the Government.

Relationship with the Pharmacy Data Transaction Service (PDTS)

The Pharmacy Data Transaction Service (PDTS) is a centralized data repository that allows a common patient medication profile to be created for all DoD beneficiaries regardless of the point of service used. Currently, claims information from non-network pharmacies is not captured by the PDTS. The PDTS was created to move the data from all Military Health System (MHS) points of service; Military Treatment Facilities (MTFs), MCSC retail pharmacy networks, and the National Mail Order Pharmacy (NMOP) contractor, to a single pharmacy claims manager that maintains the central repository. Establishing one central patient medication profile allows MHS providers to review a patient's complete medication history and reduce exposure to unnecessary safety risks that are present in a non-integrated pharmacy system.

The PDTS has allowed DoD to improve the quality of its prescription service and reduce pharmaceutical costs by conducting Prospective Drug Utilization Reviews (ProDURs). Each new and refill prescription has a ProDURs run against the beneficiary's complete drug profile. The central data repository has also allowed DoD to monitor and track patient usage and provider prescribing patterns throughout the MHS. 62,950 potential Level-I drug interactions have been identified between December 1, 2000 through December 31, 2002.

In October 2001, the PDTS Customer Service Support Center (CSSC) initiated the NMOP Conversion Project where individual patients are called and given information on the advantages of getting their prescriptions filled through the Mail Order Pharmacy. So far, this project has resulted in a savings of $1,073,406.94 in TRICARE benefit dollars.

With the use of the Business Objects Solution, the PDTS CSSC provides important data to TMA PI in Aurora and to each Program Integrity department at the MCSCs for investigational purposes. The CSSC will receive a request and provide detailed information for investigations on providers, pharmacies, and patients. The reports are password protected and sent to the requestor. In October 2002, the PDTS CSSC developed an office dedicated to handle program integrity related issues. This group's focus is on potential fraud and abuse issues and to better serve TMA - Aurora, the MCSCs, and the MTFs regarding potential fraud/abuse cases. Since October 2002, this unit has responded to 135 requests for information. In addition, proactive data research has resulted in the development of four cases. These cases are forwarded to TMA PI for additional development. Most cases have identified individual providers who may be over-prescribing controlled drugs. Prior to October 2002, approximately 114 requests for data were completed by PDTS.

For the first time, fraud and abuse measures were included in the language of the new contract for TRICARE's mail order pharmacy. Starting in March 2003, Express Scripts will take steps to deter fraud and abuse in the prescribing and dispensing of medications to TRICARE beneficiaries. Efforts will also include providing education to providers and beneficiaries. When a potential fraud and/or abuse case has been identified, Express Scripts will notify TMA PI. Specific procedures were also included to deter internal fraud and abuse by ensuring all employees undergo pre-employment screening including reference checks, background checks, criminal record checks, education verification and drug screening.

PDTS and the new Mail Order Pharmacy contractor, Express Scripts, are also active participants in TRICARE's Program Integrity Roundtable meetings. At these meetings, an environment is created where information sharing can take place across contractual boarders and ideas about fraud/abuse schemes, detection, data mining, case preparation and investigation are shared with all members.

As noted in the Pharmacy Data Transaction Service (PDTS) section on page 8, establishing one central patient medication profile that an MHS provider can review reduces a patient's exposure to unnecessary safety risks. For the purposes of identifying fraud and abuse, as well as in support of cases already under investigation, PDTS' detailed information on providers, patients, and pharmacies has proved invaluable. In the short time this system has been in operation, PDTS has become an important partner in the fight against fraud and abuse.

Section 5 - Fraud and Abuse Issues in the Philippines

A criminal investigation, headed by the Defense Criminal Investigative Service (DCIS), was initiated in 1995 following a Department of Defense Hotline complaint to investigate fraud in the Philippines. The complaint identified a conspiracy between U.S. military retirees and providers to defraud TRICARE by submitting claims for health care services that were not provided. Using the national claims history database, TMA PI substantiated the allegation of beneficiary fraud against the program. It also determined that more beneficiaries were involved than originally suspected.

In August of 2001, a task force of eight individuals from DCIS, Department of Justice, U.S. Postal Service, and TMA PI visited the Philippines. The TMA PI staff focused on verifying the existence of 13 facilities identified in TRICARE's national claims history database as having submitted claims in excess of $20,000. They verified that only two of the 13 facilities actually existed. This review of providers in Tarlac, Republic of the Philippines, then shifted to providers who had submitted TRICARE claims under $20,000. Of the 99 facilities checked in Tarlac, 79 did not exist! Since 1995, TRICARE had paid $2,436,018.35 to these fictitious providers. This information was given to Wisconsin Physicians Service (WPS), the claims processing subcontractor for the Philippines, so payments to the non-existent facilities could be stopped immediately. WPS then sent letters to all licensed providers in the Philippines requesting verification of their credentials. Providers who did not respond were terminated as authorized TRICARE providers.

As part of the DCIS focus on the investigation, 12 Philippine providers were identified that confessed to sending in fraudulent claims to TRICARE. TMA has completed sanction action against eight of those providers. A sanctioned provider is not allowed to bill TRICARE for a minimum period of five years.

Periodic meetings were held in 2001 and 2002 following the visit to the Philippines. These meetings included the Philippines Task Force members, the Director of PI, and representatives from TMA Office of General Counsel and the Program Operations Directorate, the Pacific Lead Agent, and WPS. In response to the task force findings, the Program Operations Directorate issued a special contract for on site certifications of new providers. "Bricks and mortar" certification of new TRICARE providers in the Philippines is a major improvement in efforts to curb fraud in the Philippines.

To help minimize fraud in the Philippines, additional controls have been implemented. The Defense Enrollment Eligibility Reporting System has built internal controls in their database to identify Philippine beneficiaries who are no longer eligible. The TRICARE Operations Directorate and Pacific Lead Agent established a cap on overseas pharmacy claims and were responsible for implementing the

requirement for "brick and mortar" certification. As of January 6, 2003, 227 providers have been certified and 111 denied. TMA and the Lead Agent continue to monitor the certification process closely. The Department of Justice has successfully prosecuted eleven defendants with no acquittals. Most defendants have been sentenced to over a year in federal prison. In addition, the Court has ordered the defendants to pay restitution totaling over $1,250,000. At the end of 2002, the U. S. Attorney, Western District of Wisconsin announced twelve more health care fraud indictments representing more than $650,000 in alleged losses. The indictments charge two Philippine physicians and nine military retirees and dependents with defrauding TRICARE by filing claims for services not rendered.

Section 6 - Balance Billing and Violation of Participation Agreements

TMA PI is responsible for ensuring that non-participating providers comply with Public Law 102-396, section 9011, passed by Congress as part of the Department of Defense Appropriations Act for 1993. The text of this Public Law limits the billed charges to no more than 115 % of the allowable rate. This law specifies that non-participating providers are allowed to collect a maximum of 15% over the TRICARE Maximum Allowable Charge (TMAC) from a TRICARE beneficiary.

A second type of billing violation involves participating providers. It is fraud if participating providers (those marking "yes" to accept assignment on the claim form) attempt to collect from TRICARE beneficiaries amounts in excess of the TMAC. If providers attempt to collect monies in excess of what they are entitled to collect, beneficiaries are instructed to notify the MCSCs.

Currently the contractors have a success rate of over 95 % in resolving these billing disputes. After an unsuccessful attempt by the contractor to resolve a case, the case is forwarded to TMA PI. TMA PI has been very successful in the resolution of balance billing, violation of participation, hold harmless process, waiver of liability and disputed diagnostic related group (DRG) cases.

Occasionally, providers file a summons and issue a complaint prior to referral to the TMA PI. These providers are informed that federal law takes precedence over decisions made at the local or state level. TRICARE beneficiaries cannot be held liable for charges over 15% of TMAC or for any interest, costs, or attorney fees.

Between January 1, 2002 and December 31, 2002, TRICARE received 36 violations of participation agreement cases and 20 balance billing cases. TMA PI effectively intervened and prevented the erroneous payment of $30,568.54 to providers by beneficiaries. In addition, with the assistance of the Office of General Counsel, over $125,000 was recovered for beneficiaries of dollars already paid to providers. This kind of stewardship on the part of TRICARE Management Activity makes a positive difference to the family budget of affected families.

Balance Billing Vignette 1

A network hospital in Houston, Texas, continued to violate its participation agreement with TRICARE by billing the beneficiary more than the TRICARE allowable amount in nine separate instances. The hospital received multiple educational letters advising that this pattern of billing violated its network agreement, violated TRICARE regulation, and violated federal law. The correspondence sent to the provider identified each beneficiary and date of service. The hospital was asked to issue each beneficiary a zero balance

statement and to instruct any outside collection agencies to cease all efforts to collect on these unlawful debts. To bring the hospital back into compliance, TMA PI asked the hospital to conduct a compliance audit of all TRICARE patients to determine if this same pattern of billing had taken place and provide refunds as appropriate. Within three weeks, the hospital zeroed out two more TRICARE beneficiary accounts listed as outstanding and provided training to their billing and accounts-receivable departments. The amount saved by all nine beneficiaries is $12,650.

Balance Billing Vignette 2

DCIS identified that a provider in Florida appeared to be violating the participation agreement (on participating claims) and/or balance billing TRICARE beneficiaries (on non-participating claims). The provider was contacted and agreed to the following:

1) *To cease collecting payments at the time services were rendered;*
2) *To voluntarily participate on all claims;*
3) *To refund all identified overpayments to TRICARE; and*
4) *To refund all identified overpayments to TRICARE beneficiaries.*

To assist in correcting the over-billing issues, the provider received information that helped identify overpayments for services rendered prior to May 2000. The process was lengthy and TMA PI requested the provider send a spreadsheet detailing any actions taken. There were no other complaints and the clinic informed our office that prior to our interventional efforts, balance billing had been a routine practice. Upon explanation of law and regulation, the clinic offered to correct this problem. Beneficiaries who are impacted will receive a refund along with a letter of explanation of the refund from the provider. The potential over-payments may be as high as $80,000.

Section 7 - Contract Oversight and Compliance

Control and reduction of fraud and abuse within the TRICARE program demands the vigilance of the TRICARE Program Integrity Office, the managed care support contractors, as well as the pharmacy and dental contractors, the Defense Criminal Investigative Service, and the Department of Justice. The TRICARE Program Integrity Office maintains oversight for the prevention, detection, and investigation of all TRICARE fraud and abuse cases. One very important aspect of this oversight responsibility includes monitoring of the contractor by an Alternate Contracting Officer Representative (ACOR) to ensure compliance with the requirements of the MCSC Operations Manual, 6010.49-M, Chapter 14.

Currently, there are five program integrity staff members who function as ACORs. As ACORs, the staff's primary functions include maintaining technical liaison between the Government and the contractor, performing inspections/onsite reviews, and ongoing surveillance of contractor compliance with contractual terms in the area of program integrity.

To demonstrate our continued commitment since obtaining ACOR designations in 1999, each ACOR has provided ongoing assistance and education to each contractor on what constitutes a functioning program integrity unit. During 2002, ACORs remained very attentive in their oversight duties to ensure each contractor remained in compliance. To raise the level of awareness of fraud detection and

case referrals, close contact with each of the contractors was maintained. For example, ACORs offered recommendations regarding how to properly develop and refer cases, what constituted fraud/abuse against the program, where to concentrate staff efforts, how to better utilize the artificial intelligence system, and ways to network and partner with others in the health care field. ACOR staff also provided on-site training and performed inspections on numerous occasions throughout the year. In addition, ACORs were (and continue to be) available on a daily basis in order to provide technical expertise and guidance on how to appropriately maintain a fully functional program.

Since implementing an aggressive oversight plan to ensure contractor compliance in the arena of health care fraud/abuse prevention, detection, and referral, this office and its ACORs have taken several proactive measures to enhance existing efforts in support of our mission:

- Continuing aggressive oversight of each contractor's PI unit. TMA PI is constantly in contact with each of the contractors and the lines of communication are always open.
- Development of a detailed onsite checklist for use during inspections as well as performing focused reviews which targeted areas such as case development and use of artificial intelligence software.
- Promoting importance of educational programs at contractor level - this includes educating contractor staff, provider community, and our beneficiaries.
- Continued publication of the monthly "PI Spotlight" Issues which, during 2002, focused on proactive measures to identify potential fraud/abuse within DoD.
- Creation of "Fraud Facts & Tidbits" email notices sent on an as-needed basis disseminating information to enhance awareness of health care fraud issues.

Experience has demonstrated that only through effective teamwork and a cooperative working relationship between TMA, its contractors, law enforcement, the Department of Justice, and those in the public and private sector, will the Government be able to adequately address the problem of health care fraud. During 2002, TMA PI stressed the importance of the key role each contractor had in the fight against health care fraud and abuse, which impacted the program's ability to provide quality health care to its beneficiaries. In order to raise the level of visibility of PI's mission and to highlight the importance of a strong, dedicated anti-fraud unit, each contractor is encouraged to display a continued commitment to, and an active participation in, the prevention, detection and deterrence of fraud and abuse against the program.

Our goal last year was to become a recognized leader in fraud control and looked to as an industry model for other programs to follow. We believe we've met this goal. Our new goal for the upcoming year, as well as our theme for the 2003 fraud conference, is to maintain the quality and excellence in health care fraud detection.

The single best measurement of an effective anti-fraud unit is the number of fraud referrals that are identified. In CY 1999, there were only 11 fraud referrals from all the TRICARE contractors. After implementing the requirement for artificial intelligence software, for a dedicated program integrity unit and for intensive on-site training, the numbers doubled to 22 in CY 2000. In CY 2001, all referrals began to be counted, not just those that were considered as having prosecutorial merit. In CY 2002, the numbers have remained high and the quality of the case referrals have improved.

Case Referrals

Contractors	Region	CY00	CY01	CY02
Sierra	1	0	4	8
Anthem	2&5	2	0	0
Humana (as of 6/01)	2&5	0	8	22
Humana	3&4	6	52	42
Health Net	6	4	11	4
TriWest	7&8	3	5	7
Health Net	9, 10 & 12	2	9	6
Health Net	11	0	18	5
UCCI	National	3	1	1
Humana	Overseas	2	2	1
Total Cases:		**22**	**110**	**96**

Prepayment Review

Prepayment review is one of the strategies used by the MCSC to prevent payment for questionable billing practices or fraudulent services. Providers are placed on prepayment review as part of the administrative actions taken by the managed care support contractor. The chart below shows a breakout of each contractor, the number of providers on prepayment review, and the dollars saved by the prepayment review for the period January 1, 2002 through December 31, 2002.

Contractor	Number of Providers	Dollars Saved
Health Net Federal Services, Region 6	26	$423,076
Health Net Federal Services, Region 11	0	$0
Health Net Federal Services, Region 9, 10 and 12	12	$71,686
TriWest Healthcare Alliance (Region 7 & 8)	29	$264,191
Humana Military Healthcare Services (Region 3 and 4)	160	$11,863,524
Humana Military Healthcare Services (Region 2 and 5)	78	$698,013
Sierra Military Health Services (Region 1)	23	$319,657

Section 8 - Provider Sanctions

A function of TMA PI is to track providers sanctioned by the Department of Health and Human Services, Office of the Inspector General (DHHS-OIG). An agreement between TMA PI and the DHHS-OIG enables sharing of information through provider taxpayer identification numbers. As part of the agreement, DHHS provides TMA PI with a monthly list of providers who have been excluded/terminated or suspended, and the ones who have been reinstated for the previous month. This list is used by the TRICARE MCSCs to flag providers and ensure that no payments are made to providers who have been sanctioned. TMA PI also provides the sanction list to the Lead Agents. DHHS has taken sanction action against 3,582 providers in fiscal year 2002.

TMA initiates its own sanctioning action on quality of care cases or other cases in which it may be in the "best interests of the program." TMA PI works with the TMA Office of General Counsel to sanction providers when necessary. TMA PI has completed the sanctioning process on eight providers in the Philippines who confessed to being involved in a billing fraud scheme against the program. A list of TRICARE-sanctioned providers is available through the TMA's Fraud and Abuse Web Page at www.tricare.osd.mil/fraud.

References for sanctioning or reinstating providers are cited in 32CFR199.9, Administrative Remedies for Fraud, Abuse, and Conflict of Interest and in the MCSC Operations Manual, 6010.49-M, Chapter 14.

Section 9 - Fiscal Stewardship

To be effective, fraud controls need to be built into each area of the program. TMA Program Operations has built in some excellent fraud controls in the form of Claim Check and a special duplicate edit package.

ClaimCheck

TRICARE ClaimCheck is a fully automated computer software program that contains specific auditing logic designed to ensure appropriate coding on professional claims and eliminate overpayments from these claims. The HBO and Company (HBOC) Clinical Information Services Department continually updates the ClaimCheck database and auditing guidelines with input from the Clinical Consulting Network. The Clinical Consulting Network represents a cross section of over 180 physicians with extensive clinical practice, academic work, or medical management experience. The ClaimCheck requirement started with the inception of each MCSC. ClaimCheck is monitored by the Operations Directorate and plays a key role in protecting Government dollars.

The software is designed to detect and correct the billing practice known as unbundling, fragmenting, or code gaming. "Fragmenting,""unbundling," or "code gaming" involves separate reporting of the component parts of a procedure instead of reporting a single code which includes the entire comprehensive procedure. The practice is improper and is a misrepresentation of the services rendered. Providers are cautioned that such a practice can be considered fraudulent and abusive. Every TRICARE claim is run through this system of checks and balances. It is important to note that ClaimCheck does not set coverage/benefit policy; it merely audits claims for appropriate coding.

ClaimCheck has saved millions of dollars in erroneous payments each year since TRICARE has required its use. During Calendar Year 2002, 41,942,790 claims were processed through ClaimCheck and $73,169,898 in fraudulent/abusive billings were stopped across all contracts. ClaimCheck continues to provide a substantial and impressive return on investment.

Special Duplicate Edit Software

This special duplicate edit software was developed by TMA and is used at each MCSC. Since 1997, when the software was first required, the software has identified and accounted for $64,320,515 in recoupments or offsets nationally. This software is designed as a retrospective auditing tool.

For more information on the content of this report, please contact the TRICARE Management Activity Program Integrity Office in writing at the address below.

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